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Behav Modif 2005 29: 95
DOI: 10.1177/0145445504270876

Acceptance and Commitment Therapy in the Treatment of Posttraumatic Stress Disorder

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The current article describes the application of a behavioral psychotherapy, acceptance and commitment therapy (ACT), to the treatment of post-traumatic stress disorder (PTSD). It is argued that PTSD can be conceptualized as a disorder that is developed and maintained in traumatized individuals as a result of excessive, ineffective attempts to control unwanted thoughts, feelings, and memories, especially those related to the traumatic event(s). As ACT is a therapeutic method designed specifically to reduce experiential avoidance, it may be a treatment that is particularly suited for individuals with PTSD. The application of ACT to PTSD is described, and a case example is used to demonstrate how this therapy can be successfully used with individuals presenting for life problems related to a traumatic event.

Keywords: *posttraumatic stress disorder; acceptance; combat veterans*

One of the core psychological processes thought to be responsible for the development and maintenance of posttraumatic stress disorder (PTSD) is avoidance. Active efforts to avoid or escape from trauma-related thoughts, feelings, and situations are key features of the disorder delineated in the diagnostic criteria (American Psychiatric Association, 1994). Furthermore, numbing of emotional responsiveness, arguably the most distinguishing symptom cluster of PTSD (Breslau, Peterson, Kessler, & Schultz, 1999; Foa, Riggs, & Gershuny, 1995;

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BEHAVIOR MODIFICATION, Vol. 29 No. 1, January 2005 95-129
DOI: 10.1177/0145445504270876

McMillen, North, & Smith, 2000), has been hypothesized to serve an emotional control or escape function when effortful avoidance is unsuccessful (Foa, Riggs, Massie, & Yarczower, 1995). Thus, it is no surprise that the common element across several successful PTSD treatment approaches involves prescribing the direct opposite of avoidance and escape and full exposure to and processing of trauma-related internal and external cues.

Although there is promising empirical support for several of these approaches in the reduction of trauma-related fear and avoidance (Rothbaum, Meadows, Resick, & Foy, 2000), additional treatment development and refinement efforts are indicated for a number of reasons (discussed more fully below). Exposure therapy, perhaps the best documented treatment choice for PTSD given its strong theoretical rationale and empirical support, has not consistently demonstrated a superiority across all outcome measures as compared to other treatments, such as stress inoculation training (Rothbaum et al., 2000). Furthermore, to date, treatment outcome has been measured primarily on relatively narrowly defined outcome variables (e.g., statistical change in PTSD symptom level), with less attention paid to the clinical significance of these changes and their impact on quality of life. Given the complexity of PTSD and the high rate of comorbidity associated with the disorder (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), research on the impact of our extant treatments for PTSD on these variables is strongly indicated. Finally, the widespread dissemination of empirically established treatments to the diverse population of therapists and clients has been hindered by fears in both groups about activating and tolerating difficult memories and emotions in therapy. The disseminability and acceptability of treatment approaches are important factors to be considered when evaluating the effectiveness of a treatment (Kazdin, 1998). Although the first approach to this limited dissemination should be (and has been) to more fully educate therapists and clients to the potential benefit and limited risk associated with exposure therapy, it is also possible that therapy approaches, which directly include methods designed to reduce fear and avoidance of internal experiences, may be useful in treating clients who may otherwise refuse exposure therapy or drop out of treatment.

One treatment approach that may address some of these limitations and potentially deserves consideration in the treatment of PTSD is acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999). Acceptance and commitment therapy is a behavior therapy based on functional contextualism (Biglan & Hayes, 1996; Hayes, 1993; Hayes et al., 1999). Readers interested in the conceptual model and the experimental work on rule-governed behavior and relational frame theory, from which ACT was developed, are referred to the ACT text (Hayes et al., 1999), as well as Hayes, Barnes-Holmes, and Roche's (2001) *Relational Frame Theory: A Post-Skinnerian Account of Human Language and Cognition* as a full presentation of this literature is beyond the scope of the applied article. Clinically, the model suggests that experiential avoidance or escape, the engagement in strategies designed to alter one's experience of private events, is a process that underlies many forms of psychopathology (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). The methods used in ACT are specifically directed at decreasing the client's use of avoidance or escape strategies in coping with unwanted thoughts, emotions and memories and at increasing their acceptance of, or willingness to experience, these private events while engaging in previously avoided behavioral action.

Acceptance and commitment therapy is not solely focused on symptom reduction as an outcome. Although many successfully treated ACT clients report a reduction in symptoms, a major focus of ACT is, instead, to increase clients' ability to make and keep commitments to behavior change. Specifically, clients are encouraged to identify valued directions and goals in their lives and to commit to actions that are consistent with these values. Thus, in addition to symptom reduction, ACT is aimed at improving the components of a client's life that are deemed to be important by that particular client. This idiographic approach to defining the clinical significance of changes associated with treatment may address some of the shortcomings that come from operationalizing clinical significance a priori using a particular outcome measure that may or may not represent the individual's ability to function better in some palpable way in his or her everyday life (Kazdin, 1998).

The purpose of this article is to provide a clinical description of how ACT may be delivered in the treatment of PTSD. Although empirical support for the use of ACT in the treatment of PTSD is still limited (Batten & Hayes, in press), we have found it to be a useful approach for patients who refuse exposure therapy, and we are currently working on treatment development efforts designed to test the efficacy of this approach. There have been a number of recent applications of integrating methods of acceptance and mindfulness into the traditional cognitive-behavioral treatment of anxiety and mood disorders (Orsillo, Roemer, & Barlow, 2003; Roemer & Orsillo, 2002; Teasdale et al., 2002), which offer some preliminary support for the potential use of these methods. In the current article, we attempt to provide a useful clinical description of the use of ACT for PTSD, including some case material and some specific metaphors developed by Hayes et al. (1999) in the space provided. However, we refer the reader to the ACT text (Hayes et al., 1999) for a more detailed delineation of the general methods used in this approach.

Before we describe the use of ACT with a PTSD client, we will briefly summarize the empirical evidence supporting the role of avoidance in the development and persistence of trauma-related problems, such as PTSD. We will also briefly review the empirical support for currently available PTSD treatments, discuss limitations of these treatments, and suggest ways in which ACT potentially addresses these issues.

THE ROLE OF AVOIDANCE IN PTSD

Studies from a variety of literature support the premise that avoidance and escape behaviors play fundamental roles in the development and maintenance of PTSD and trauma-related problems. Thought-suppression studies have shown that attempts to control thoughts are often ineffective and can paradoxically increase the frequency of unwanted thoughts and distress associated with them (Purdon, 1999; Roemer & Borkovec, 1994; Wegner, 1994). This suppression effect has been found to be particularly strong among women with rape-related PTSD (Shipherd & Beck, 1999). Furthermore, a general tendency to suppress thoughts about unpleasant events has been shown to

be predictive of short-term intrusions following the viewing of a disturbing film (Davies & Clark, 1998).

Studies of self-reported coping strategies, although correlational, have also provided support for the potential role of avoidance in PTSD. Avoidant coping styles, such as wishful thinking and attempted suppression of negative material, have been shown to be associated with posttraumatic symptomatology across samples of female assault victims (Valentiner, Foa, Riggs, & Gershuny, 1996), ambulance workers (Clohessy & Ehlers, 1999), motor vehicle accident victims (Nightingale & Williams, 2000), Gulf-War veterans (Benotsch et al., 2000), and African American youth exposed to inner-city violence (Dempsey, 2002; Dempsey, Overstreet, & Moely, 2000). Although these coping strategies are associated with more significant psychopathology in general, Amir et al. (1997) found that the use of suppression as a coping strategy was significantly more characteristic of individuals with PTSD than those with other anxiety disorders.

Similarly, dissociation, which has been behaviorally conceptualized as a regulatory or control process that occurs in response to trauma cues (Wagner & Linehan, 1998), has been linked to increased PTSD symptomatology. Specifically, retrospective reports of dissociative symptoms at the time of the traumatic event have been correlated with current severity of PTSD symptoms (Bremner et al., 1992; Marmar et al., 1994; Tichenor, Marmar, Weiss, Metzler, & Ronfeldt, 1996). Prospective studies have also shown that dissociative symptoms postnatural disasters significantly predict PTSD symptoms 7 to 9 months later (Cardena & Spiegel, 1993; Koopman, Classen, & Spiegel, 1994; although some mixed findings exist, e.g., Marshall, Spitzer, & Liebowitz, 1999).

Additionally, two prospective studies assessing the fluctuation of posttraumatic symptoms over time found that individuals who showed a delayed peak reaction reported more severe symptomatology at both 12 weeks and 6 months after the trauma (Gilboa-Schechtman & Foa, 2001). In other words, those individuals whose peak symptom reaction occurred shortly after the assault had lower levels of PTSD and depression than individuals whose peak reaction occurred later in the course of the study, pointing to the potential role of avoidance in the development of posttraumatic symptomatology.

EMPIRICALLY SUPPORTED TREATMENT APPROACHES FOR PTSD

Given that avoidance and escape behaviors seem to be important factors in the development and maintenance of posttrauma psychopathology, reduction of avoidance or escape would seem to be a fundamental goal of PTSD treatment. A number of psychotherapy approaches for PTSD, varying in their emphasis on avoidance or escape reduction, have shown significant promise in reducing symptoms when compared to wait-list control conditions. Many of these are package or combined treatments consisting of multiple elements that have, thus far, not been dismantled to determine the relative efficacy of each component part. For instance, anxiety management training, which typically involves teaching clients an assortment of behavioral and cognitive strategies to enhance their capacity to manage the emotional responses associated with PTSD, has been shown to be effective in reducing PTSD symptoms. One such treatment, Stress Inoculation Therapy (SIT; Foa, Dancu, Hembree, Jaycox, & Meadows, 1999; Foa, Rothbaum, Riggs, & Murdock, 1991), has been compared to exposure therapy and found to result in significant reductions in symptoms for female rape survivors, although with weaker long-term effects than exposure therapy.

Resick and Schnicke (1992) have also developed a treatment package, cognitive processing therapy (CPT), specifically for rape-related PTSD, which combines elements of exposure therapy, anxiety management skills, and cognitive restructuring. CPT has been found to be far superior to a wait-list comparison group on clinician ratings and psychometric inventories of PTSD (Resick, Nishith, & Astin, 2000).

Another combination treatment of PTSD that has received considerable attention and controversy in the literature is eye movement desensitization and reprocessing (EMDR; Shapiro, 1989; Shapiro, 1995). EMDR combines components of exposure therapy and cognitive therapy with repeated sets of lateral eye movements. Although EMDR has been demonstrated to be effective, as compared to no treatment, critics have argued that the mechanism of action is likely to be exposure and that the addition of eye movements is neither theoretically nor empirically indicated.

One of the most strongly supported treatments for PTSD, and a common element in all of the packages described above, is exposure therapy. The basic practice of exposure therapy, whether in vivo or imaginal, involves presenting the client with physical or imaginal cues related to the trauma (e.g., location of the trauma, objects or conditions associated with the trauma, memories of the trauma) while promoting the prolonged experience of affect that may be elicited when remembering with the traumatic event(s). The goals of exposure therapy are the reduction of avoidance and the habituation of emotional responding to these conditioned cues. The efficacy of exposure therapy for PTSD has been demonstrated with combat veterans (Black & Keane, 1982; Fairbank & Keane, 1982; Keane & Kaloupek, 1982) and rape survivors (Foa et al., 1991), as well as clients with PTSD stemming from many different traumatic events (Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998; Richards, Lovell, & Marks, 1994; Tarrier et al., 1999). In randomized, controlled clinical trials, exposure therapy has been found to be equally effective as cognitive therapy for PTSD, which is the combination of cognitive therapy and exposure therapy, anxiety management training, the combination of anxiety management and exposure therapy, and cognitive processing therapy (Foa et al., 1999; Marks et al., 1998; Tarrier et al., 1999). Thus, the extant data support the use of exposure therapy in the treatment of PTSD (Keane & Barlow, 2002).

LIMITATIONS OF EXTANT TREATMENTS FOR PTSD

In summary, there appear to be several treatments (exposure therapy, CPT, EMDR, and anxiety management techniques, such as SIT) that are effective in the treatment of PTSD for many individuals. Exposure therapy, a common element across these treatments, is strongly recommended in the treatment of all individuals with PTSD unless otherwise indicated (Rothbaum et al., 2000). However, there are some limitations to the use and potential efficacy of exposure therapy and the other empirically supported treatments reviewed above.

First, although the treatments described above have been found to reduce PTSD symptomatology, not all clients requesting treatment of posttraumatic symptoms fit into a classic PTSD presentation. For example, the focus of exposure, thus far, has primarily been on a fear response. However, many traumatized individuals struggle with a variety of emotional responses, including sadness, disgust, guilt, shame, or anger. Although some cognitive therapies, such as CPT, address these responses—and there is some evidence that exposure, CPT, and other therapies reduce symptoms of depression (Foa et al., 1991)—the specific efficacy of these approaches in reducing distress associated with the myriad forms of emotional responding is unknown. Furthermore, certain patterns of emotional responding common to PTSD have, in fact, been shown to diminish the efficacy of exposure therapy. For instance, exposure therapy was shown to be less effective for individuals with high levels of pretreatment anger (Foa et al., 1995) and among those who were perpetrators of harm and experience guilt as a primary emotional response (Pitman et al., 1991). Although it may be the case that such clients would do worse in all treatments, it is possible that a treatment such as ACT, which is specifically designed to address one's responses to the full range of emotional experience, could be beneficial.

In addition, the focus of traditional therapies for trauma survivors has been primarily on the reexperiencing and hyperarousal symptoms of PTSD, and treatment outcome has, for the most part, been assessed in terms of PTSD symptom reduction. Given the high rate of comorbidity (Kessler et al., 1995; Orsillo et al., 1996) and low levels of quality of life (Mendlowicz & Stein, 2000) associated with PTSD, more attention to the treatment of the widespread problems of living among individuals, particularly with chronic PTSD (e.g., difficulties in relationships, occupational problems), seems indicated.

Finally, although the efficacy of exposure therapy has been repeatedly demonstrated, many clients are unwilling or unable to tolerate the focused approach required for true exposure therapy and, thus, may refuse this form of treatment. There is also some evidence that the more significantly emotionally avoidant individuals with PTSD may be, the less likely they are to benefit from exposure therapy. Research documents that those clients who display more intense facial fear

expressions (Foa et al., 1995) and those who report higher subjective anxiety ratings (reflecting higher emotional engagement; Jaycox, Foa, & Morral, 1998) in the first session of exposure therapy benefit more from such treatment.

However, by the very nature of their diagnoses, individuals with PTSD are often unwilling to emotionally engage with their traumatic memories. They are also more likely to hold negative attitudes about the expression of emotion (Joseph et al., 1996; Nightingale & Williams, 2000), which may interfere with their ability to engage in emotional processing. Thus, individuals with PTSD are characteristically avoidant, yet the treatment of choice for PTSD works best with clients who are emotionally engaged.

To address this possible paradox, proponents of exposure therapy have suggested that therapy should include a discussion about the importance of emotional engagement before exposure begins, so as to overcome potential obstacles in treatment (Jaycox et al., 1998). However, chronic avoidance patterns are likely to be highly resistant to change, and clients may not respond even after participating in a discussion that includes a strong rationale for exposure. Given the proven efficacy of exposure therapy and the clear identification of this issue as a barrier to success, future treatment developments devoted to increasing willingness to be open to one's emotional experiences seem necessary.

RATIONALE FOR CONSIDERING ACT IN THE TREATMENT OF PTSD

Given the proposed importance of avoidance in the development and persistence of PTSD and the proven efficacy of exposure therapy in treating PTSD, any new developments in the treatment of PTSD must incorporate these constructs into their methods. Furthermore, new developments should address the limitations described above. It is our assertion that ACT has the potential to address many of the shortcomings described above and to reduce the avoidance characteristic of PTSD. We conceptualize ACT as a treatment that can target the avoidance of (and escape behaviors from) private experiences (includ-

ing traumatic thoughts and fear or anxiety, as well as other emotional states such as guilt or anger) and can facilitate exposure while bringing about meaningful and clinically significant change in a client's life.

As described above, ACT is a contextual behavioral therapy based on the assumption that many of the symptoms seen across the range of psychopathology represent efforts to avoid or escape emotions, thoughts, memories, and other private experiences (Hayes et al., 1996). For instance, substance use, dissociation, self-injurious behavior, and behavioral avoidance all may function to change negative internal states. Acceptance-based therapies have been applied to several clinical problems, including substance abuse (Hayes et al., 1999; Marlatt, 1994), psychotic symptoms (Bach & Hayes, 2002), and generalized anxiety disorder (Orsillo et al., 2003; Roemer & Orsillo, 2002). Thus, ACT can be used with individuals with a wide variety of diagnoses, comorbid conditions, and problems in living (e.g., relationship problems, occupational problems, etc.). Additionally, ACT can and does address the full range of emotional responses and is not limited to a fear-based conceptualization of PTSD.

Another important aspect of ACT is that it is explicitly directed at increasing quality of life. Clients are directed to examine their own valued life directions, to acknowledge the ways in which attempts at avoidance and escape have prevented them from living the life they desire, and to commit to behavior change. Improved quality of life as an outcome is emphasized over symptom reduction.

Finally, the overarching goals of ACT interventions are to decrease experiential avoidance and escape and to introduce a stance of acceptance and willingness (Hayes et al., 1999), concepts that will be described more fully below. Although a delineation of the methods by which a therapist could encourage a potential exposure-therapy candidate to fully engage in emotional processing has yet to occur in the PTSD-treatment literature, ACT offers a variety of methods to facilitate increased experiential openness.

APPLICATION OF ACT TO PTSD

CASE EXAMPLE

To describe the application of ACT for individuals with PTSD, we will refer to a composite case example, "Bill," throughout the description of the treatment. Bill was a 51-year-old Vietnam combat veteran who was being seen at a veteran affairs hospital for treatment of PTSD and major depression related to his history of service in Vietnam. At the beginning of treatment, Bill reported intrusive memories, nightmares, panic attacks, and significant problems with feelings of guilt associated with acts that he had committed in Vietnam. He also described a limited range of emotional experience and a long history of attempts to avoid and escape emotional experiences, including emotional suppression and past problems with alcohol use. At the beginning of treatment, Bill was unwilling to discuss his experiences in Vietnam in much detail and would stop such discussions as soon as he began to experience feelings of guilt, anger, or sadness. Although Bill had been able to hold a long-term job, he had significant problems with absenteeism from work; he also had notable problems in interpersonal relationships and had been divorced three times.

As part of the informed consent process, we described our conceptualization of Bill's difficulty from an ACT perspective and provided him with an overview of the treatment. We discussed how some therapies target negative thoughts and feelings and attempt to change them through systematic refutation. We suggested that our approach was different in that we would not be focused on reducing negative internal experiences through the use of internal control strategies. Therapeutic targets were also discussed, and we jointly committed to the goal of improving the quality of Bill's life in lieu of beginning with an objective of reducing emotional pain. Finally, we suggested that our approach was somewhat different from prolonged exposure (PE), a method of treatment that has demonstrated efficacy. Bill was not willing to pursue PE at the time he presented to our clinic, and he contracted with us to engage in ACT.

ASSESSMENT

As with other therapies grounded in basic behavioral principles, the significance of thoughtful assessment of treatment progress is stressed in ACT. Careful assessment of client functioning at the beginning of treatment is important to provide a baseline by which to assess the client's progress both during and at the end of treatment. Furthermore, as ACT is a treatment still under empirical investigation, the potential contribution of carefully controlled studies of the provision of ACT by therapists in the field provides another impetus for a thorough assessment of its implementation.

General Assessment Measures

As a general rule, the assessment process should include measurement of the presenting symptoms that are most relevant to the client. Although the primary focus of ACT is not on symptom reduction, it is still important to assess the presenting symptom level of clients—both so that the client feels that the therapist is attending to the issues for which the client has begun therapy and because such measures are generally required to be able to assure treatment effectiveness for managed care providers. In addition, we would suggest the use of measures that assess quality of life, given that one of the stated goals of ACT is to improve important variables related to life choices (a review of quality of life measures is beyond the scope of the current article). One way in which we attempt to measure this construct in an idiographic and personally meaningful way is to have the client rate the importance and consistency of their behavior in a number of valued life domains (see a fuller description of values below). In the case of Bill, the initial assessment included the values assessment, self-report measures of depression, anxiety, PTSD, life satisfaction, and a clinician-administered measure of PTSD symptomatology.

Assessment of Avoidance and Suppression

Assessment should also include measures of experiential avoidance and thought suppression, constructs that are proposed to be im-

portant in the conceptualization of PTSD from an ACT perspective. For example, the Acceptance and Action Questionnaire (AAQ; Hayes et al., in press) is a 9-item measure that has been specifically developed for the measurement of experiential avoidance. The items on the AAQ consist both of statements indicative of avoidance and emotion-focused inaction (e.g., "When I feel depressed or anxious, I am unable to take care of my responsibilities") and reverse-scored items indicative of emotional acceptance and action (e.g., "I'm not afraid of my feelings"). Higher scores on the AAQ indicate higher levels of experiential avoidance and emotion-focused inaction. The internal consistency of the AAQ is acceptable for a measure in development (Cronbach's alpha = 0.70), and convergent validity is demonstrated with a number of measures of thought suppression, general psychopathology, depression, anxiety, a variety of specific fears, and trauma-related symptoms.

Other relevant instruments might include the White Bear Suppression Inventory (WBSI; Wegner & Zanakos, 1994) or the Thought Control Questionnaire (TCQ; Wells & Davies, 1994), two measures of the tendency to suppress or control unwanted thoughts. The WBSI is a 15-item self-report measure used to assess tendency toward thought suppression, the respondent's desire or ability to avoid a thought. Higher scores on the WBSI are indicative of greater desire to use or successful use of thought suppression. The WBSI has high test-retest reliability, internal consistency (Cronbach's alpha = .89), and convergent validity (Muris, Merckelbach, & Horselenberg, 1996). The TCQ is a 30-item self-report instrument designed to identify how frequently individuals use different strategies of thought control. The measure has five subscales with adequate internal consistency (alpha range = .64 to .83). The Self-Punishment and Worry subscales on the TCQ are positively correlated with psychopathology, whereas the Distraction, Social Control, and Reappraisal subscales are negatively correlated with psychopathology (Amir, Cashman, & Foa, 1997; Reynolds & Wells, 1999; Warda & Bryant, 1998). Our client, Bill, was given the AAQ and the WBSI at the beginning of treatment, and his scores indicated moderately high levels of avoidance and suppression.

Values Assessment

In addition to measures of symptomatology, avoidance, and suppression, ACT also includes a formalized values assessment that has been created specifically to capture an individual client's treatment targets. As conducted in its complete form, the values assessment protocol in ACT is comprised of three components: generation of values narratives; rating of values narratives; and identification of goals, actions, and barriers (Hayes et al., 1999). For the purposes of this assessment, values are distinguished from goals. Values are described as the general directions that a person wishes to head in a particular life domains (e.g., living a healthy lifestyle), whereas goals are the specific behavioral actions to be accomplished in the service of a particular value (e.g., exercising 4 days a week and eating more fruits and vegetables). Thus, it is important to clarify the larger set of values that are important to the client before identifying specific goals to be accomplished.

The first step of the values assessment process involves asking the client to generate a brief description of his or her values in each of several areas of life that are often considered important (e.g., family, intimate relationships, employment, health, spirituality). This is often done as a homework assignment, although it can be completed in session when clients are unwilling or unable to generate narratives as homework. Client and therapist then review these descriptions together and transfer the important points in each area onto a single values narrative form. Initially, Bill was assigned the values narrative assessment as homework. Although he partially completed the form, several domains were left blank and many of the narratives he produced were superficial ("I want to help others") or they included impossible goals ("I want to erase the problems I caused my first wife"). We worked with Bill on several sessions to refine these narratives. For instance, we helped Bill to identify values that mattered to him, regardless of what other people might think of them. Furthermore, the general direction of being a kinder, more considerate partner was derived from his initial goal of magically removing the pain caused by his past behavior. Moreover, specific behavioral actions consistent with this value were identified, such as listening more

closely to his partner and taking her preferences into consideration when making a decision.

The second step of the values assessment process begins by transferring the values narratives to a values assessment rating form. This rating form includes three rating scales. On the first scale, the client is asked to rate the absolute importance of each valued domain to the client, irrespective of the other domains. On the second scale, the client is asked to rate how successfully he or she has lived life over the past month with respect to each of the valued areas. On the third scale, the client is asked to rank each of the 9 or 10 valued domains, with respect to each other, to determine which areas are most important overall to the client. The purpose of this rating form is to help orient both the client and therapist to the areas that deserve primary focus in treatment, either because these values are of highest importance to the client or because the client is having the most difficulty in living a life consistent with those values. In the case of Bill, the areas of family and intimate relationships were identified as the most important to him, and the domain of employment was chosen as an area in which he was having the most trouble acting in a way that was consistent with his values.

The final step of the values assessment process involves generating goals, actions, and barriers related to each of the valued domains. Goals are described as specific achievements to be accomplished in the service of a particular valued life direction. After potential goals that are important to the client have been identified, then the actions that will need to be taken to achieve those goals are listed. For example, Bill wanted to work on the goal of going to work every day and arriving on time. The actions necessary to accomplish this goal involved leaving for work a half hour earlier each day and not calling in sick when he was emotionally upset. The last step of this assignment is to identify potential barriers that may get in the way of taking these actions. If the barriers are things that can be practically changed, then those changes become yet more actions to take. However, if the barriers are emotions or other private events, then the goal of therapy becomes working with the client to increase his or her willingness to have those emotions and still engage in the valued action (as discussed further below).

THERAPEUTIC TARGETS AND INTERVENTIONS

Creative Hopelessness

In ACT, one of our initial treatment goals is to help the client become aware of the relative effectiveness (or ineffectiveness) of the strategies that he has employed thus far to deal with his unwanted private events. Often, this work results in the client being able to observe these strategies in the context of what we refer to as "creative hopelessness." Frequently, our clients will become aware that the things that they have been trying to feel better about have only made things worse. In fact, if the strategies they characteristically employ were effective, why would they need to be in therapy at this time? Thus, creative hopelessness is the sense that what has been done so far both has not worked and will not work, with the prospect that a new way of looking at things may lead to a different outcome.

When Bill initially presented for therapy, his stated goal was to remove his negative private experiences related to Vietnam, including intrusive memories; nightmares; physiological sensations; and feelings of sadness, anxiety, and guilt. He had a long history of attempting to control and eliminate these experiences using suppression techniques (self-talk and distraction), alcohol, and previous psychotherapy experiences. Not surprisingly, Bill had ultimately found these control attempts to be unsuccessful and, in some cases, damaging. Thus, although he hoped that this therapy would finally provide him with the ability to change his internal experiences, he also felt somewhat pessimistic that we could provide a simple solution to his distress.

In the creative hopelessness phase of ACT, the therapist offers a number of specific verbal and experiential methods to help the client to observe the actual workability of the culturally sanctioned and seemingly rational strategies that the client has been using to date. The client is not simply instructed that such strategies are wrong or that they are not working. Instead, the ACT therapist invites clients to determine for themselves what their goals are (e.g., to get rid of painful memories, to develop intimate relationships), to elaborate on the methods that they have used to attempt to achieve these goals (e.g., alcohol use, self-talk, behavioral avoidance), and to mindfully evalu-

ate the effectiveness or workability of these strategies (Hayes et al., 1999). In contrast to traditional cognitive-behavioral therapy (CBT), the goal of this phase of ACT is not to verbally challenge clients or not to persuade them to see their situation differently. Instead, clients are encouraged to focus on the reality of their own experiences rather than on the rules they have developed for how things should be.

In this phase of therapy, both in session and as part of homework, Bill was asked to examine all of his previous attempts at dealing with his problems and to honestly evaluate the success of his previous efforts. A number of metaphors were used to facilitate his ability to learn from his direct experience rather than clinging to the notion of how things should work based on individual and culturally shared learning histories and verbally defined rules.

For instance, the man in the hole metaphor was given to illustrate the self-defeating control struggle in which Bill was entangled when he originally presented for therapy. Bill was asked to

> imagine that you're placed in a field, wearing a blindfold, and you're given a little tool bag to carry. You're told that your job is to run around this field, blindfolded. That is how you are supposed to live life. And so you do what you are told. Now, unbeknownst to you, in this field there are a number of widely-spaced, fairly deep holes. You don't know that at first—you're naive. So you start running around and sooner or later you fall into a large hole. You feel around and sure enough, you can't climb out and there are no escape routes you can find. Probably what you would do in such a predicament is take the tool bag you were given and see what is in there; maybe there is something you can use to get out of the hole. Now, suppose the only tool in the bag is a shovel. So you dutifully start digging, but pretty soon you notice that you're not out of the hole. All this effort and all this work and oddly enough the hole has just gotten bigger and bigger and bigger. Isn't that your experience? So you come to me thinking, "Maybe (s)he has a really huge shovel—a gold-plated steam shovel." Well I don't. And even if I did I wouldn't use it, because digging is not a way out of the hole—digging is what makes holes. So maybe the whole agenda is hopeless—you can't dig your way out, that just digs you in. (Hayes et al., 1999, pp. 101-102)

Other metaphors were also used in this stage of therapy to illustrate how stuck Bill was in his current situation. The Chinese handcuffs metaphor, which reminds the client of the paradoxical need to push in,

rather than pull out, to make the woven straw tube (Chinese handcuff) bigger, was introduced to help Bill explore the workability of his current agenda and the potential of an alternative approach to living that would provide him with more space in which to move around. Also, the tug-of-war-with-a-monster metaphor was useful to Bill in suggesting the potential necessity of letting go of his struggle with internal experiences.

> The situation you are in is like being in a tug-of-war with a monster. It is big, ugly, and very strong. In between you and the monster is a pit, and, so far as you can tell, it is bottomless. If you lose this tug-of-war, you will fall into the pit and be destroyed. So you pull and pull, but the harder you pull, the harder the monster pulls, and you edge closer and closer to the pit. The hardest thing to see is that our job here is not to win the tug-of-war. . . .Our job is to drop the rope. (Hayes et al., 1999, p. 109)

Control as the Problem

If the ACT conceptualization fits for a particular client, then creative hopelessness will usually set the stage for the client's recognition that his or her agenda to manage internal experiences has not been successful in any long-term or meaningful way. Thus, the next phase of treatment focuses on identifying the functional commonalities between the client's previously ineffective strategies for dealing with certain private experiences. From an ACT model, attempts to control or eliminate unwanted private experiences are often at the heart of such unworkable approaches. In this case, the conceptualization of control as a key factor in the development and maintenance of PTSD did appear to fit well for Bill, and he was able to begin to notice that control was not a workable strategy for his own life enhancement. Nevertheless, actually moving away from control efforts was incredibly difficult for him. Thus, a number of clinical methods were used in an attempt to help Bill decrease his habitual efforts at control.

First, experiential exercises were conducted to demonstrate the limits of experiential control efforts on changing internal states. Bill was asked to imagine himself hooked up to a sensitive polygraph machine and told to control his anxiety or risk death. He was also asked to imagine being paid a million dollars to fall in love with some-

one he had just met. In both cases, Bill responded by noticing that even with the highly motivating conditions of the two situations, he was sure that he could not will himself to feel certain emotional states such as calmness or love.

Hayes et al. (1999) discuss several factors that maintain the continued use of control strategies for managing private events despite the limitations and costs associated with this approach, and many of these were explored with Bill in his therapy. First, we discussed the rule of private events, which states that purposeful control is actually quite successful as a strategy for affecting change in the external world; but when applied to internal events (e.g., memories, feelings), it backfires. With overt behavioral change, if a goal is established (e.g., "I would like to clear my driveway of ice and snow"), one can make up a list of actions that need to be done (e.g., shovel, put down rock salt) and execute the list to achieve success. In contrast, if a person decides that a feeling, thought, or memory needs to be changed (e.g., "I am evil because of the acts I committed in Vietnam"), making up a list of cognitive- and emotional-change techniques and implementing them (e.g., think a different thought, do not feel guilty anymore) does not result in meaningful, long-term change. We discussed with Bill how the apparent success of control in the exterior world makes it very difficult to give up applying this strategy to internal experiences, even in the face of a lifetime of evidence of the ongoing failure of this approach.

The influence of society and Bill's family of origin in maintaining his strong belief that emotional control was a plausible and worthy goal was also discussed in therapy. Bill described how his father had always appeared to have control of his emotions and how he had demanded that Bill and his siblings keep their negative feelings in check. Bill was able to reflect back on his father's chronic struggle with alcoholism as an indicator that he, too, had a problem with the willful avoidance of negative internal experiences.

Finally, we discussed how attempts to change private events might even appear to be effective in the short term, perpetuating the continued use of these techniques despite their limited success and high cost. For example, drinking alcohol to avoid or escape thinking about Vietnam may seem perfectly effective over the course of an evening, thus

reinforcing the use of these strategies. However, the pain and unwanted thoughts associated with the situation will not go away permanently because of a night of drinking. In fact, the frequency or intensity of these reactions may increase as a result of the avoidance or escape, and the use of alcohol may create a number of new and painful internal and external experiences.

At this point in therapy, Bill was ready to consider an alternative to the control agenda that he had been using, and the two scales metaphor was provided as an introduction to this next phase of work. Essentially, this metaphor suggests that there are two scales in front of the client: one labeled *distress* and the other *willingness*. Bill had been focused on attempting to bring down the distress scale, and he had overlooked the presence of the willingness scale. Unfortunately, the distress scale reflects a reaction, something on which Bill has little control. In contrast, the willingness scale is something that can be volitionally set at high or low. The willingness scale refers to how accepting an individual is to his or her own experience as it occurs, without needing to alter it in any way. We suggested that Bill's willingness scale was generally set at 0, which was locking his distress scale in at 10. We also suggested that therapy would be focused on choosing to set the willingness scale at a high level. In contrast to traditional CBT approaches to exposure, we did not suggest that setting willingness high would result in a lowering of distress. Instead, we suggested that setting willingness to high would allow for some variability in distress, rather than being locked into a chronic, high state of distress.

Willingness

Once it has been set up that increasing willingness will become a primary target of therapy, it becomes necessary to more fully define what we mean by willingness. Willingness is sometimes described as a feeling; however, in ACT we are concerned with willingness as an activity. For example, this may mean being willing to come to therapy every session, even when the client does not feel like doing so. Willingness, the feeling, may come and go, but willingness, the activity, is required. This example can be especially relevant for trauma survivors, many of whom may have a history of dropping out of therapy or

engaging in therapy-interfering behaviors when the subject matter becomes painful.

Willingness is also differentiated from the construct of wanting. In ACT, the therapist clearly communicates to the client that pain is not something that should be encountered because it is heroic to do so. It is natural and self-protective to automatically move to avoid or escape negative and painful experiences. However, when that protective response causes the client to avoid acting in accordance with his or her chosen life direction, willingness is an option that should be considered. This component of willingness is illustrated in the swamp metaphor:

> Suppose you are beginning a journey to a beautiful mountain you can clearly see in the distance. No sooner do you start the hike than you walk right into a swamp that extends as far as you can see in all directions. You say to yourself, "Gee, I didn't realize that I was going to have to go through a swamp. It's all smelly, and the mud is all squishy in my shoes. It's hard to lift my feet out of the muck and put them forward. I'm wet and tired. Why didn't anyone tell me about this swamp?" When that happens, you have a choice: abandon the journey or enter into the swamp. Therapy is like that. Life is like that. We go into the swamp, not because we want to get muddy, but because it stands between us and where we are going. (Hayes et al., 1999, p. 248)

This metaphor is an important one for trauma survivors, as we want to make clear that we are not asking our clients simply to choose to begin to face the difficult memories, feelings, and life choices associated with their traumatic events simply for the purpose of slogging through the swamp. We go through the swamp for the purpose of getting to the mountain, which represents the client's own valued life directions.

The all-or-nothing quality of willingness is also described to the client to underscore the point that willingness cannot be qualitatively limited. For example, at one point early in the therapy, Bill suggested that he would be willing to talk with a woman from his neighborhood with whom he was interested in developing a relationship, as long as he did not start to feel a panic attack coming on. This statement does not reflect a willing stance, and, thus, we worked with Bill to develop an action that he could commit to regardless of the development of any unwanted internal experiences.

A number of images and metaphors are used in this phase of ACT to help elucidate for the client the concept of being willing to experience thoughts and feelings in the service of regaining control of one's life. However, the primary work in this phase of therapy involves experiential, in-session practice of willingness. As the client begins to develop valued life directions and commits to taking action outside of therapy to improve his or her quality of life, willingness is discussed and practiced as the method by which the client can create a meaningful life. When conducting ACT with a client with PTSD, this phase often includes exposure to internal experiences related to the traumatic event. This work is discussed in more detail below (under the heading *The Role of Imaginal Exposure to Trauma-Related Cues in ACT*).

Given the habitual nature of experiential avoidance among many clients presenting for treatment of PTSD, a great deal of work in ACT is focused on increasing willingness and acceptance of private events. As we have discussed, illuminating the unworkability to date of the client's avoidance agenda and reconnecting the client with the reasons that he or she might choose to adopt a willing stance (e.g., his or her valued directions) are important strategies used to increase willingness. However, these methods are unlikely to be potent enough to encourage change with an individual who has suffered chronically with PTSD. Acceptance and commitment therapy has been described as a treatment that requires a high price from its clients (Hayes et al., 1999): that verbal defenses are reduced and psychological monsters are faced. And in the case of individuals who have experienced a traumatic event, such monsters may seem virtually impossible to approach. To face such monsters directly, it is helpful to engage in new practices that allow a different way of moving toward the difficult private experiences that have thus far been viewed as unacceptable. Deliteralization and identifying the self as context are two such methods.

Deliteralization as a Method of Increasing Willingness

Deliteralization is a term used in ACT to describe the disruption of the usual meaning functions of words and language, with such disruption designed to help clients let go of excessively literal interpretations of their own thoughts. In our culture, words are usually seen as equivalent to the things that they describe. This can explain why the verbal

description of a traumatic event in therapy can be just as painful as the initial experience of the event. As a result of deliteralization, however, a thought may be not only verbally understood, but also heard as a sound or observed as an automatic verbal reaction. For example, a trauma survivor may learn to be willing to experience the thought, "I do not deserve good things in my life," as just a thought, rather than as something to be believed or challenged. Deliteralization is practiced in ACT through the use of verbal conventions and exercises designed to remove some of the power given to thoughts when they are understood as real things that must be taken seriously.

For example, Bill adopted several verbal conventions that were designed to help him identify his thoughts as just thoughts and to allow him to notice how often he was letting his verbal judgments of events, himself, and others to function as reality. For instance, he began defining thoughts and feelings as such, for instance replacing "I am anxious" with "I am having the feeling of anxiety". He also began to replace the word "but" with "and" when describing situations such as "I wanted to go in to work, but I was anxious and depressed," as a first step in undermining the role of his private events in dictating his behavior.

Identifying Self as Context for Willingness

In ACT, it is proposed that emotional willingness is only fully achievable in the context of an unchanging self that is not threatened by difficult psychological content; that is, our clients must learn through their experience that they will not be destroyed by allowing themselves to feel, think, or remember whatever is present for them naturally. Often, we will use experiential exercises, such as mindfulness training or the Observer Exercise to help a client practice being aware of all of his or her private experiences without struggling to control them. Mindfulness has been described as a state in which one is fully observant of external and internal stimuli in the present moment and does not attempt to judge or change any aspects of the current situation (Kabat-Zinn, 1994; Segal, Williams, & Teasdale, 2002). Through mindfulness exercises, the client is taught several ways to be aware of his or her private events without judging them or becoming caught in the content of those experiences. In the Observer Exercise,

the client is taken through a series of steps in which she is asked to notice that, at a basic level, the person that she is remains constant, regardless of the thoughts, feelings, memories, or roles that she has had throughout her lifetime (for a complete description of the Observer Exercise, see Hayes et al., 1999). Such exercises are used to demonstrate to the client how difficult private events can be experienced without being completely overwhelming. Bill reported that the Observer Exercise was very powerful for him, and we were subsequently able to work more directly on traumatic memories that he had been avoiding to talk about because he had been afraid that approaching such memories would cause him to fall apart or go crazy.

Commitment to Action

In the final phase of ACT, the client makes commitments to take action toward valued life directions, and the methods described thus far are used to facilitate the client's movement. At this point in therapy with Bill, he had identified his struggle with control efforts as problematic, and he was open to choosing a willingness stance. Thus, we began working with him to make some commitments about the direction in which he wanted to take his life. Bill had been chronically struggling with his depression, PTSD and alcohol problems, and he had neglected the areas of his life that were important to him, such as intimate relationships and work. Using the values assignment that Bill completed as part of his initial assessment, we began the work of developing his commitment to action in the areas he personally valued.

Several metaphors were used to demonstrate how willingness is the critical ingredient to sustain committed action. The Joe-the-bum metaphor was described in which the client is asked to imagine that an unwanted guest arrives at a party that was open to all. In this metaphor, Bill was asked to consider whether he could hold a negative evaluation of Joe and not want Joe to be present and still allow him to stay at the party. The contrast, Bill limiting his willingness to accept unwanted guests, was demonstrated by imagining Bill guarding the door for possible unwanted guests while the party went on without him. This metaphor demonstrates the need to be open to all experiences, even unwanted ones, if one wishes to be able to fully live life.

Bill was asked to make a commitment to take action in the areas of life that mattered to him, which would require him to be willing to experience all the anxiety, joy, and pain that would likely accompany such a choice. The nature of committed action as a process was demonstrated through the use of a gardening metaphor. We suggested that once Bill made a commitment to a particular plot of land then he would likely begin to see the flaws in his choice (too much sunlight, not enough moisture) and consider changing locations over and over again. However, it was suggested that, with this approach, Bill would only be able to grow light crops, such as lettuce or parsley. An ongoing commitment to a garden plot, accepting all the imperfections of the conditions, would be necessary to grow the heartier, more sustaining crops, such as potatoes.

Bill identified a willingness to work on developing intimate relationships. Throughout the remainder of therapy, he was asked to commit to specific actions related to that valued direction on a weekly basis. With every success and failure, we examined the workability of a willing versus an unwilling stance toward internal experiences that arose with each assignment, along with the ultimate goal of strengthening Bill's commitment to live a personally valued life. At times, when Bill appeared unwilling to engage in action consistent with his reported values, we explored whether the value was truly meaningful and personal to him or if it reflected the wishes of his social environment (including perceived demand characteristics of the therapist). Following this analysis, Bill would either reconnect to his value, modify it to be more in line with his personal preferences, or maintain an unwillingness to bear the cost (negative thoughts and feelings) of a valued life direction. Bill was urged to continue to evaluate the workability of whichever outcome he chose.

For instance, Bill committed to contacting his estranged daughter to tell her that he wished to reestablish a relationship. However, he repeatedly failed to follow through with this assignment because he was afraid that the action would bring up feelings of guilt and memories of his mistreatment of his family in the past. The cost of not having a relationship with his daughter in the service of avoiding unpleasant or escaping internal experiences was examined in session, and components of valuing and willingness were continuously discussed.

Eventually, Bill followed through on the assignment and continued to commit to new, related actions.

However, in another example, Bill committed to filling out paperwork necessary for him to go back to school to complete some college coursework. Despite several sessions devoted to willingness, Bill continued to avoid this action. Finally, an in-session analysis of his behavior led to the realization that Bill did not truly value a return to college. Instead, he was very interested in pursuing a job in woodworking and cabinetry, an interest he had held for many years. However, Bill's belief that his family (and his therapist) would respect him more if he had a college degree was encouraging him to pursue a value that he did not personally endorse. This realization allowed Bill to alter his values statement and to make a commitment to his desired occupation.

SPECIAL CONSIDERATIONS FOR THE APPLICATION OF ACT WITH TRAUMATIZED INDIVIDUALS

Issues Specific to Childhood Trauma

There are several advantages of ACT as a treatment of trauma-related problems that underscore the potential use of this approach with survivors of childhood trauma: The client does not have to meet full criteria for PTSD, a clear memory of a specific traumatic event is not needed, and comorbid conditions can be addressed in the context of the treatment. However, there are some adaptations to ACT that might ultimately improve the efficacy of this approach with childhood trauma survivors.

For instance, individuals who have experienced a significant trauma early in life may have an especially difficult time with a sense of self. The self has been conceptualized behaviorally by Kohlenberg and Tsai (1991) as the ability to describe certain experiences that are evoked by private stimuli as "I see, feel, want, etc." Some trauma survivors go on to have significant problems labeling such experiences simply based on private stimuli and are, thus, more under the control of public stimuli to label how they are feeling. These individuals may require more work to recognize the constancy of a private observer self who will remain intact and constant, regardless of the emotions, thoughts, or memories experienced or the external stimuli in whose

presence they are experienced. Furthermore, early childhood abuse is often associated with the frequent experience of intense negative emotions (such as fear, anger, or sadness), which may make clients even more hesitant to adopt a willingness stance.

We have found that incorporating some skills-training techniques from dialectical behavior therapy (DBT; Linehan, 1993), another acceptance- and change-based behavioral approach, can supplement the methods from ACT designed to increase willingness, particularly with early childhood trauma survivors. For example, mindfulness skills from DBT can supplement the Observer Exercise and other ACT methods of developing a sense of self that is not dependent on impermanent private events. Furthermore, DBT offers some skills in its emotion regulation and distress tolerance modules that may facilitate the sense of perspective from one's emotional experience that ACT aims to achieve. Although it is our clinical experience that these methods can complement the techniques of ACT, we suggest that some caution should be used when adapting this protocol. ACT is aimed at developing some distance and differentiation between individuals' sense of self and their private experiences so that clients can turn from avoidance and inaction to participation in a valued life. However, for the beginning ACT therapist, methods directed at gaining a sense of perspective and methods that are intended to change one's internal experience can be difficult to distinguish. The guiding principle to adding techniques to ACT should be that each new method is consistent with the therapist's conceptualization of the case and focus on the reduction of experientially avoidance and escape strategies.

Working Through Obstacles and Barriers

Individuals with PTSD or other trauma-related problems often come to therapy with the conceptualization that their current problems are caused by the traumatic event. Because the historical occurrence of the event cannot be altered, it can seem as if the client can never recover. When it becomes apparent that the client might bear some responsibility for making choices in the current moment that could improve or maintain his or her current level of distress and dissatisfaction, the client can feel invalidated and threatened. In other words, if

he or she can improve life now, without erasing the traumatic event from history, perhaps the event itself is not entirely responsible for his or her current distress. Or if the client no longer appears to be the victim of the event, it may somehow minimize the awfulness and wrongness of the event.

This can often be a stuck point for individuals with trauma histories and, thus, needs to be directly addressed in therapy. Acceptance and commitment therapy offers several metaphors for illuminating to the client that the cost of having behaviors in the present be defined by the traumatic experiences of the past. One is the legal concept of corpus delecti: that if there was a murder, there must be a body. Sometimes our clients have spent the majority of their lives serving as the dead body to prove that a crime was committed. Another useful metaphor is to think of the client and the perpetrators of the traumatic event as on the same fishhook. It may be that there is no way for the client to get off the hook without first letting others off. These metaphors help to illustrate that the responsibility for recovering from a traumatic experience lies ultimately with the client, even if the responsibility for the original traumatic experience does not.

The Role of Imaginal Exposure to Trauma-Related Cues in ACT

As discussed earlier, in-session experiential exercises are used to help the client adopt a willingness stance to painful internal experiences. Depending on the specific clinical presentation, such exercises may be more or less centered on traumatic material. For many clients, we ask them to describe the traumatic event that was experienced while, at the same time, not avoiding or attempting to escape the thoughts, feelings, or bodily sensations that may arise. Although this approach is topographically similar to prolonged exposure therapy, in ACT, we are clear to emphasize that the goal of such experiential practice is not the reduction of anxiety or other posttraumatic symptoms. Rather, the intention is to demonstrate to clients that they no longer need to struggle with their own experiences. The memories or feelings associated with the trauma may be painful; however, it is only the struggle with such thoughts and feelings that is destructive in their lives, not the thoughts and feelings themselves.

This emotional exposure to trauma reminders may develop in two ways. In some cases, we make an explicit agreement and commit to working on the trauma memories as part of the ACT therapy process. In other cases, emotional exposure to trauma memories is practiced when it becomes clear that the avoidance of memories and related thoughts and feelings is serving as a significant barrier to the client moving in a valued direction. For instance, with a female incest survivor, we may make the decision in a particular session to engage in an exposure exercise with abuse-related memories when she presents for the third session in a row, without completing her behavioral assignment, to become sexually intimate with her partner because her unwillingness to experience these memories is an obstacle to her completing this valued activity. We believe that this approach to exposure may increase the willingness of a previously reluctant client to experience her private events, because the purpose and benefit of doing may be more obvious and salient than in systematic prolonged exposure.

Finally, in other cases, we might take a hierarchical approach to emotional exposure. Early on in treatment, it can be advantageous to begin with a focus on more generalized issues of avoidance and willingness, reassessing over time the need to then extend such willingness more directly to posttraumatic reactions. This is the approach that was taken with Bill. Because he was initially not receptive to discussions of specific details of his experiences in Vietnam, despite his high levels of distress and guilt related to his service, we had to first work with Bill to practice experiential willingness with respect to going to work every day and experiencing more currently relevant emotions, such as loneliness. It was only after he had learned a different way of engaging with his private events in his current life that he was willing to approach the traumatic material for which he had initially sought therapy.

Therapeutic Relationship and Role of the Therapist

Acceptance and commitment therapy is an emotionally intense form of therapy for both the client and the therapist. Because of the difficult issues addressed in this treatment, especially with trauma survivors (many of whom have been in painful and invalidating interpersonal situations), it is particularly important that there be a strong ther-

apeutic relationship through which to do this work. The therapeutic relationship in ACT is based in an understanding that therapists and clients are fundamentally no different from one another, in that language allows all humans to struggle with their own private experiences in a way that cultivates experiential avoidance (Hayes et al., 1999). Thus, ACT therapists do not take a one-up position from the clients they treat; instead, they are able to take a step back and serve as an observer and a guide through the traps of language, avoidance, and escape toward a life that is valued by the client.

Acceptance and commitment therapy also requires that the therapist be aware of the impact of his or her own experiential avoidance on the conduct of the therapy and work toward maintaining a willing stance. Therapists are expected to have thoughts and feelings reflecting their own personal experiences of fear, incompetence, frustration, anger, sadness, fondness, and any other variety of reactions during the course of conducting ACT therapy with a client with PTSD. However, although these private events are universal, they can also be painful and uncomfortable to experience. It is important that the ACT therapist not damage the work of therapy in the service of attempting to avoid or escape from these private events. For example, therapists should be vigilant that they do not subtly discourage the client from discussing difficult traumatic material or suicidal or self-harming thoughts in session simply because it serves the purpose of keeping the therapist from becoming uncomfortable. Instead, the therapist must practice the same skills of willingness and commitment in session and be willing to discuss difficult private experiences with a supportive supervisor or colleague. Overall, although necessary for effective treatment, the therapeutic relationship in ACT is not seen as sufficient for change by itself. However, when practiced in a way that is consistent with ACT, the therapeutic relationship can be a powerful model of acceptance, willingness, and valued behavior.

SUMMARY

In conclusion, there still remains much work to be done in the refinement and dissemination of effective treatments for individuals with PTSD. Although extant treatments are effective for many trauma

survivors, more research is needed on both more traditional and potentially more novel approaches to ensure their acceptability, long-term efficacy, and impact on life satisfaction and quality of life. Furthermore, future developments in treatments for PTSD that specifically target variables that are predictive of good treatment response with exposure therapy, such as openness to one's emotional experience, should be supported. We believe that ACT is one treatment that may hold potential for addressing these issues and improving the treatment of posttraumatic problems in living.

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